NEW JERSEY DEPARTMENT OF HEALTH
PUBLIC HEALTH SERVICES
DIVISION OF FAMILY HEALTH SERVICES

Central Intake for Maternal, Infant and Early Childhood Services

REQUEST FOR APPLICATIONS

Issued by:

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REQUEST FOR APPLICATIONS (RFA)

I. INTRODUCTION

The New Jersey Department of Health (NJDOH), Division of Family Health Services (FHS), Maternal and Child Health Services is announcing a competitive request for applications (RFA) to support community-based programs for Central Intake for Maternal, Infant and Early Childhood Services. The NJDOH has partnered with the Department of Education, through the Race to the Top Early Learning Challenge (RTT) to expand the current Central Intake system from 15 to all 21 counties of the state. The following counties are eligible for Central Intake funds: Bergen, Cape May, Hunterdon, Morris, Sussex, and Warren.

Improving maternal and infant health is a priority of the NJDOH prevention agenda. Key population maternal and child health indicators including low birth weight and preterm birth have improved slightly over the last decade in NJ, yet significant racial, ethnic and economic disparities persist. The overall trend in first trimester prenatal care for New Jersey mothers has improved since the release of the 2008 Prenatal Care Task Force Report, from 77 to 82 percent in 2013 (provisional EBC data). While improvements in rates of timely prenatal care have occurred across all groups, significant racial/ethnic disparities persist. (See Appendix A for statewide trend data) Further challenges for maternal and infant health include the implementation of comprehensive preconception / interconception care and supporting services for tobacco cessation, substance abuse, mental health, and domestic violence.

High-risk women include those who are low-income or uninsured; racial, ethnic and linguistic minorities; women with chronic health conditions; women with multiple social or economic stressors; underserved immigrants; victims of domestic violence; individuals with mental health, alcoholism and/or substance abuse issues; and women with unintended pregnancies. These women and their families are more likely to be without a medical home and are less likely to access consistent, comprehensive preventive and primary care services. (Ref 1- 8)

Funded programs will work to improve utilization of these maternal and infant health services, as strategies to reduce rates of preterm birth, low birth weight, and infant mortality. The evidence-based system of care model to be implemented, Central Intake, is also informed by the “life course” approach to healthcare delivery. This approach features the development of supports, opportunities and social norms that promote and facilitate healthy behaviors across the lifespan. A life course approach to improving birth outcomes is recommended by several national MCH organizations. (Ref 9, 10, 11)

The Central Intake process coordinates the services and supports that are best suited for the family’s particular needs. The process is based on self-referrals and referrals from other professionals such as primary care providers, prenatal care providers, hospitals, child care providers, community health workers, and other providers. Families with children and women of childbearing age will be referred and linked to medical care, early intervention services and other health and social services, as needed.

Central Intake agencies are also tasked with maximizing the aggregate impact and appropriate utilization of available and often scarce resources. Working with partners, Central Intake hubs will eliminate duplication of effort and streamline access to healthcare and social services and other community supports at the county level.

Description of Problem and Need

Improving access to preconception care and early prenatal care is essential to promoting the health of New Jersey mothers, infants, and families. Early prenatal care is the traditional opportunity to support healthy pregnancy through risk assessment, health education, and the management of pregnancy-related complications and conditions. Early prenatal care is necessary but not always sufficient to improve birth outcomes and eliminate disparities. Successful pregnancy outcomes have been shown to be directly linked to the basic health of women.

According to New Jersey 2011 Pregnancy Risk Assessment Monitoring System data, one in every three pregnancies (36.1%) in New Jersey is unintended (mistimed or unwanted). Unintended pregnancies may result in delayed access to prenatal care and a reduced opportunity for screening and interventions for negative health behaviors, such as tobacco or alcohol use, that can lead to poor birth outcomes. High rates of unintended pregnancy can lead to serious socioeconomic consequences and contribute to significant disparities in reproductive health and pregnancy outcomes, particularly among young, poor, and minority women. PRAMS data shows that even among intended pregnancies, only 40% of mothers reported receiving preconception counseling. National and New Jersey data show no significant decline in the overall proportion of unintended births (mistimed or unwanted). (Ref 12)

New Jersey Behavioral Risk Factor Surveillance System (BRFSS) data indicate the following prevalence rates of other high risk conditions among New Jersey women of reproductive age (ages 18-44 yrs.) that can cause adverse birth outcomes. (Ref 13)

•About 2.1% of women 18-44 years in New Jersey have diabetes (2012 New Jersey Behavioral Risk Factor Survey)

•About 11.4% of women 18-44 years in New Jersey have current asthma (2012 New Jersey Behavioral Risk Factor Survey)

•About 18.8% of women 18-44 years in New Jersey are obese (2012 New Jersey Behavioral Risk Factor Survey)

•About 11.5% of women 18-44 years in New Jersey have a history of diagnosed hypertension (2011 New Jersey Behavioral Risk Factor Survey)

•About 16.5% of women 18-44 years in New Jersey are current smokers (2012 New Jersey Behavioral Risk Factor Survey) Unintended pregnancy and late prenatal care contribute to higher prevalence of otherwise modifiable risk factors among New Jersey women. Using data from the 2011 NJ Pregnancy Risk Assessment Monitoring System (PRAMS, Ref 14):

•40.5 % of mothers were overweight or obese (BMI >25) prior to pregnancy

•17.8% of mothers were smokers at any time during pregnancy

•24.7% of mothers drank alcohol weekly before pregnancy

•19.7 % of mothers did not have or had late prenatal care during pregnancy

•22.6% of mothers were uninsured prior to pregnancy

Poor health preceding pregnancy compromises fetal development prior to the initial prenatal visit. Although early and regular prenatal care is important, planning for pregnancy and being at optimal health prior to pregnancy are keys to improving a woman's chance of having a healthy pregnancy and baby. The primary purpose of this RFA is to increase the identification of women who are at high risk and link them to preconception care and or prenatal care aimed at improving preconception health and pregnancy outcomes.

The goal of preconception care is to reduce the risk of adverse health effects for the woman, fetus, or neonate by optimizing the woman's health and knowledge before planning and conceiving a pregnancy. (Ref 15) Because reproductive capacity spans almost four decades for most women, optimizing women's health before and between pregnancies is an ongoing process that requires access to and the full participation of all segments of the healthcare system. (Ref 15) Although interventions tend to focus on women, these preconception health opportunities are important to both women and men across the life course, regardless of pregnancy intention. Preconception care provides the opportunity for the development of a reproductive life plan consistent with a person's values and life goals. (A reproductive life plan involves thinking about goals for school, for job or career, and for other important things in life, and then considering how having children fits in with those goals).

To significantly improve pregnancy outcomes, supporting services such as mental health assessment, domestic violence assessment, dental assessment, HIV counseling and testing and substance abuse counseling must often be included in the plan of care. Women with chronic pre-pregnancy conditions such as diabetes and hypertension known to benefit from early pregnancy management have not experienced increases in first trimester prenatal care. A more comprehensive system of care is needed to provide health promotion, screening and interventions for women of reproductive age to reduce a woman's risk factors, especially when pregnancies have not been planned.

History

In 2008, a task force of stakeholders was convened to identify an approach for improving New Jersey's rate of first trimester prenatal care. The Commissioner's Task Force on Prenatal Care produced a report highlighting goals and objectives along with a list of recommended actions to work towards improving rates of early prenatal care. (Ref 16) To address some of the recommendations related to access to early care, nine agencies in high-risk areas were identified and awarded grant funds to implement evidence-based programs that focused on improving access to early prenatal care.

In 2010 the NJDOH Office of Local Public Health released a report entitled "Improving the Health of New Jersey's Communities" that identified high-priority health issues identified by twenty-two public health partnerships through outreach to their public health care partners. The report is on the Department's website (Ref 17). Each partnership developed a Community

Health Improvement Plan (CHIP) that identifies methods to address the individual health issues. Representatives from hospitals, community services organizations, government, educational institutions, faith-based organizations, medical, social services and non-profit groups, participated in the project. The results of the report are being used by local health agencies statewide to develop specific plans to address the high-priority public health issues. The public health issues identified in the project included substance abuse screening/treatment, smoking cessation and prenatal care.

New Jersey's Early Learning Plan

In January 2014, the Department of Education in collaboration with the Departments of Health, Human Services, Children and Families and the NJ Council for Young Children developed the New Jersey Early Learning Plan that incorporates a prenatal to age eight approach to services. A key component of the New Jersey Early Learning Plan is the expansion of the Central Intake model to all 21 counties.

New Jersey's Early Learning Plan (NJ Plan) establishes a progression of standards to meet the complete health and safety needs of infants and young children. The targets will increase the numbers of high-needs children who receive health screening, follow-up and referrals, and annual well-child visits. The standards integrate health and developmental screening and follow-up and promote children's physical, social, and emotional development as well as support parents in promoting their children's comprehensive health. This plan specifically addresses the health care needs of infants and young children within and through:

1) the progression of standards in Grow NJ Kids Tiered QRIS (Quality Rating Improvement System) for high needs children in the mixed-delivery system of early learning and development programs;

2) health standards/performance measures currently in place for the state's expansive network of Evidence-based Home Visiting programs; and

3) Central Intake hubs that support early developmental screening and strengthen links between families, health providers, and early learning and developmental programs.

Improving Pregnancy Outcomes Initiative

The Improving Pregnancy Outcomes (IPO) Initiative utilizes Central Intake hubs to refer women and their families to needed medical and other community support resources. A key component of the IPO is the utilization of Community Health Workers to locate hard to reach women and their families and then to refer them to Central Intake. This seamless process involving Central Intake increases the efficiency of the referral process and reduces the potential for duplication of efforts and services.

At the core of IPO is the life course approach whereby a woman's needs are addressed at multiple points in time: preconception, prenatal and post conception in order to ensure that a woman is as healthy as possible prior to becoming pregnant as well as during and after her pregnancy. This initiative also recognizes that, in addition to addressing the needs of the woman, it is also important to address the needs of the family.

The New Jersey Department of Health(NJDOH) /Family Health Services(FHS) endeavors to use

the available IPO funds to drive and support innovations to ultimately build a practice base of evidence tested through continuous quality improvement (CQI). To accomplish this, IPO, as well as this RFA, incorporate the following key guiding models, principles and approaches within a comprehensive public health framework:

A Performance Management Approach to measuring, monitoring and improving health. Performance management is the practice of actively using performance data to improve the public's health. The performance management framework centers on a clear and focused aim and the strategic use of performance standards to guide the development and implementation of specific improvement strategies. Applicants will be asked to show how chosen improvement strategies align with a core set of performance standards and the needs of their community, and will work with NJDOH to develop relevant performance measures used to monitor the effectiveness of those strategies. It is expected that grantees will continuously monitor progress in improving defined short-and longer-term outcomes, and refining strategies to improve effectiveness. (Ref 10)

A Life Course Perspective that promotes optimal women's health throughout the reproductive lifespan. The Life Course Model looks at health as an integrated continuum and suggests a complex interplay of multiple determinants, considering the impact of social, environmental, biological, behavioral and psychological factors on individuals throughout their lives. It builds on recent social science and public health literature that posits that each life stage influences the next and that social, economic and physical environments interacting across the life course impact individual and community health. A Life Course Perspective recognizes that as many as one half of all pregnancies are unintended, underscores the importance of promoting a woman's health regardless of her pregnancy plans, and expands the focus on improving pregnancy outcomes from prenatal care alone to include preconception and interconception care and wellness. (Ref 9)

A Social Ecological Model approach recognizes health as a function of individuals and the environments in which they live; including family, peer, neighborhood, work place, community and societal influences. A Social Ecological Model identifies and addresses health determinants at multiple ecological levels to strengthen individual knowledge and skills; enhance social networks and supports; change organizational practices; mobilize communities; and influence policy. (Ref 18)

Community Health Worker Model (CHW). Also known as lay health advisors, natural helpers, indigenous helpers or promotoras, CHWs are paraprofessionals who are trusted members of the target community to whom other community members turn for a variety of social supports. Based on social support and social network theories of health promotion, CHWs have been used across a variety of public health initiatives to enhance multiple aspects of individuals' social networks and supports, which in turn can improve health outcomes by modeling and reinforcing positive health behaviors and practices, buffering the impact of stress, and facilitating access to and utilization of resources, including health care and other community services. Research studies demonstrate that CHWs can improve health outcomes, address disparities, improve the utilization of preventive and primary care services and reduce the need for intensive services among high-need populations. (Ref 19, 20) In counties with CHWs,

Central Intake hubs will work closely with these CHWs to ensure that clients receive referrals in a seamless fashion.

Central Intake for Maternal Infant and Early Childhood Services

Central Intake for family support programs provides one single point of entry, at the county level, for access, assessment and referral to medical and other family support services. The Central Intake model coordinates all screening referrals, whether from a prenatal provider, a community agency, outreach worker, or a self-referral, through one central agency (Appendix A). This type of systems integration assists prenatal care, pediatric and adult primary care providers (including Federally Qualified Health Centers), outreach workers, and early learning providers (child care centers, Head Start/Early Head Start, Home Visitors, etc.) in making referrals, coordinating follow-up and tracking service connections (feedback loop), especially in large, fragmented systems.

Central Intake works closely with community partners to investigate all possible sources of outreach to women and their families and integrates these organizations as partners in the system of care. Through screening and risk assessment, women and their families are offered linkages to appropriate medical providers, home visitation and community-based services. In addition, Central Intake hubs provide linkages to mental health services, family counseling, social emotional screening providers, Early Intervention, and other supports. Successful implementation requires local community collaboration, consensus building, and careful planning and infrastructure development that is horizontal (e.g., prenatal, pediatric and adult primary care providers) and vertical (e.g., outreach and community based prevention programs, home visitation agencies and clinical facilities).

NJDOH/FHS places significant emphasis on building and strengthening a collective system to assure that risk factors are systematically and routinely identified, documented and addressed through Central Intake. These efforts should focus both on improving systems within health care practices and on building reciprocal linkages between health care and other community providers that serve high-need families, including WIC, home visiting, early child care and education, early intervention, mental health and substance abuse, domestic violence, income assistance and other community programs. Postpartum care visits provide an additional opportunity to assess maternal medical, behavioral and psychosocial risks, provide information on infant care and birth spacing, and assure ongoing health care and management plans are in place for preexisting or developing chronic conditions. (Ref 21, 22) During the postpartum period, linking families to pediatric health and social services is another opportunity to engage families in wellness.

Central Intake functions include:

- Promoting universal screening of pregnant women
- Connecting women and families with needed resources and community based referrals including:
  - Health Care (prenatal care, reproductive health care, and adult and pediatric primary care)
  - Behavioral Health Care (mental health intervention, tobacco cessation, addiction

treatment)

- Maternal Infant and Early Childhood Home Visiting Programs
- Domestic Violence Shelters and Support Services
- Educational Attainment – Literacy, GED, ESL, Vocational, College
- Family Social Support / Fatherhood Support Programs
- Financial Assistance / Employment Training / Life Skills Development
- Infant and Child Care / Early Childhood Services / Early Intervention
- And other available community services and supports

•Putting agreements in place with prenatal providers for receipt of referrals

•Implementing a system to receive screens/referrals (in collaboration with providers)

- For self-referred women and families, screening with the Community Health Screen will be performed by Central Intake.

•Coordinating training of participating providers/agencies in how the screen is used and transmitted to Central Intake, including 4 Ps Plus, depression screening; and how clients/patients will be linked to available resources.

•Implementing a feedback mechanism to referring providers, especially prenatal providers, for their records

•Ensuring that intake staff are well trained to make an initial determination of the woman and her family's needs, including:

- Prevention education
- Perinatal health
- General health
- Social issues and family support
- Financial needs and eligibility / public assistance General Assistance (GA), TANF Temporary Initative for Parents (TIP), Food Stamps, emergency assistance, Supportive Assistance to Individuals (SAI), NJ FamilyCare, etc.

•Implementing triage criteria for linkage to an initial assessment

- Coordinates with outreach to locate women/families without telephones
- Provides linkages for an initial assessment for medical care
    - Preconception
    - Prenatal
    - Women's health (primary care)
    - Pediatric/well child care

- Providing linkages for an initial assessment for home visiting
  - Nurse Family Partnership (NFP)
  - Healthy Families
  - Parents as Teachers (PAT)
  - Early Head Start/Head Start
  - Other Home Visiting Programs – HIPPY, Parent-Child Home, etc.
  - Family Success Centers / Family Resource Centers
  - Infant/Toddler Childcare Centers
  - Pre-K or other childcare centers
- Providing infrastructure for Maternal, Infant, and Early Childhood Home Visitation (MIECHV) sites in defined communities in New Jersey
  - Assuring that referrals to MIECHV programs are timely, appropriate, unduplicated and coordinated
  - Tracking and reporting all aspects of the referral and enrollment process in MIECHV programs in defined communities and statewide, including:
    - Universal screening of all pregnant women for perinatal risk factors
    - Referral to and enrollment of pregnant women in home visiting programs
    - Referral of families who are not eligible for home visiting programs to other community resources and supports
- Coordinating a plan for outreach and education either directly or thru partners
  - Pregnancy testing sites
  - Key prenatal/reproductive health providers
  - Behavioral health providers
  - Welfare and other social service agencies
  - Schools
  - Community agencies
  - Pregnant women/families in the community
  - The general public
- Implementing and maintaining a standardized data tracking system
- Convening a designated advisory board consisting of MCH providers, community health workers, social service agencies and consumers that meets quarterly.

Collaboration and Approach

Based on their community assessments, grantees will select and implement relevant evidence-based or best practice activities, and/or develop and implement innovative evidence-based strategies.

Using a structured performance management framework, grantees will regularly assess their progress in implementing strategies and achieving desired outcomes, and will continually refine improvement strategies to enhance or expand effective strategies and revise or discontinue those that are less effective. NJDOH/FHS will provide additional guidance and technical support to grantees on performance measure development, data collection and reporting systems, and quality improvement methodology.

II. PROPOSAL REQUIREMENTS

Target Population

The following counties are eligible to apply for the expanded Central Intake funds: Bergen, Cape May, Hunterdon, Morris, Sussex, and Warren.

The applicant shall clearly delineate the population to be served through improvement in perinatal indicators including access to preconception, prenatal, and interconception care and an improvement in pediatric indicators. The project area is defined as the specific **county** in which the proposed services are to be implemented. Racial and ethnic disparities in health outcomes in the target county must be addressed.

Applicants may propose to target more than one county. However, a **separate application must be submitted** and will be reviewed and scored separately for each county the applicant proposes to serve. The number of counties and the expected number of individuals served will be taken into consideration when determining the final award amounts.

PRA/SPECT data system (Required)

- The Grantee shall utilize the PRA/SPECT data system to conduct grant-related activities. This includes submitting demographic, assessment, service, and patient referral data for clients using the PRA/SPECT System. The PRA/SPECT (Single Point of Entry and Client Tracking System) is the required data system for use by grantees for grant-related activities. The Grantee is required to complete a business agreement and a data sharing agreement for PRA/SPECT with Family Health Initiatives within 45 days of the grant award.

- The Perinatal Risk Assessment (PRA) is required (See Appendix E). This form will be used by providers as a referral tool for client services including, but not limited to home visitation, social services, health care, WIC, and other needed community services.

    - The PRA is intended to promote early and accurate identification of prenatal risk factors and to reduce administrative burden on busy obstetric practices. Risk assessment is conducted during pregnancy during the first prenatal visit to identify women who are at high risk for fetal or infant death or infant morbidity. The goal of risk assessment is to prevent or treat conditions associated with poor pregnancy outcome and to assure linkage to appropriate services and resources through referral. Early identification and intervention are keys to prevention, therefore risk assessment is conducted at the first prenatal visit and updated throughout the course of prenatal care. The PRA is a standard two-page screening form that determines demographic, medical and psychosocial risk factors during pregnancy. The PRA includes the 4*Ps Plus* to screen for tobacco, alcohol and other drug use; perinatal depression and domestic violence (see Appendix F).

    - High-risk status is based on objective data in three key areas: 1) demographic factors, e.g. age, municipality, marital status; 2) medical risks, e.g. parity (prior pregnancies and live births), prior birth outcomes (fetal/infant death, preterm, low birth weight); current positive screen for alcohol, tobacco and other drug use, depression, domestic violence; and 3) economic and psychosocial factors, e.g. TANF, WIC, insurance status, housing, language/cultural barriers. The PRA will be used by providers as a referral form for home visitation or other needed community services and supports.

- The Community Health Screening Form is required to be used by community health workers and central intake staff for women, men and children as the standardized screening tool. (See Appendix F)

    - Like the PRA, the Community Health Screen identifies the needs of clients for subsequent referral by Central Intake. The Community Health Screen is designed to be used for all clients, regardless of whether or not they are pregnant. The Community Health Screen has the PRA embedded in it which includes the 4 Ps Plus. The Community Health Screen, if not already completed by a community health worker, shall be completed by Central Intake staff.

- Initial health screening forms, completed by community health workers and community based organizations, are also received by Central Intake.

Central Intake Hubs will be responsible for management of partner agreements and will triage and track referrals to additional services including**:**

- initial medical assessments: preconception, prenatal, women's health (primary care), pediatric/well child care, behavioral health
- home visiting, case management, community based agencies, or center-based programs
- outreach services to locate women/families without telephones

Evaluation, Outcomes and Performance Standards

- Applicants must propose a plan for evaluating the project, and the evaluation plan must include both process and outcome measures
- Applicants must explain how the proposed project addresses chronic disease risk factors and will improve health outcomes
- All grantees will be expected to incorporate Quality Improvement (QI) activities to critically review the effectiveness of chosen strategies. Once performance standards and accompanying data sources have been defined, data should be reviewed on a "real time" basis to provide rapid cycle feedback about performance to promote continuous quality improvement. These QI activities should lead to adjustment of improvement strategies as needed to optimize their effectiveness. Grantees will be required to submit quarterly reports that reflect critical review of progress and performance standards data and any resulting changes to improvement plans. Improvement plans will be formally updated annually as a condition of continued grant funding. Central Intake partners should be fully engaged in these activities. Improvement plans should reflect engagement of the target population in development of strategies and assessment of progress. Through these activities, the IPO initiative will help develop a body of "practice based evidence" related to improving maternal, infant and child health outcomes among high-need populations and communities.
- As a condition of funding, grantees will be required to participate in any evaluation activities directed by the NJDOH/FHS. It is anticipated that these evaluation activities will build directly upon the performance management activities described above.

Performance Standards for Central Intake for Maternal Infant and Early Childhood Services:

The applicant should work to develop objectives that will enhance or implement the Central Intake model. All grantees will be expected to collect, review and report a set of defined performance standards to monitor and assess the implementation and effectiveness of improvement strategies. The specific performance standards will be developed as part of Year 1 implementation in close consultation with NJDOH/FHS.

It is anticipated that performance standards will include a set of uniform core performance standards for the entire IPO initiative that will be reported by all grantees, as well as additional process and outcome measures specific to each IPO project. Data sources for performance standards likely will include a combination of Perinatal Risk Assessment data and data collected and reported directly by grantees to NJDOH (e.g., client level data from community health worker activities) and data analyzed and reported to grantees by NJDOH (e.g., community level vital statistics or Medicaid enrollment/utilization data).

The following table illustrates potential performance standards:

Performance Standards for Central Intake for Maternal Infant and Early Childhood Services		
Performance Standard Label	**Definition**	**Definition of Measurable Improvement**
Number of women identified for necessary services	Number of participating women identified for necessary services (need list of necessary services)	Increase over time in the proportion of women screened for necessary services by a standardized assessment tool (PRA and Community Health Screen).
Number of women needing services & receiving a community resource referral	Number of participating women identified as requiring a service by a standardized assessment tool and who received a referral to an available community resource	Increase over time in the proportion of participating women identified as requiring a service and who received a referral to an available community resource.
Number of MOUs with other social service agencies in the community	Number of MOUs with other social service agencies in the community	Increase or maintain over time in the number of MOUs each provider has with health/service agencies
Information sharing: Number of agencies where provider has a specific contact w/ collaborating community agency	Number of agencies with which the provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies	Increase or maintain over time in the number of agencies with which each provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies
Number of completed referrals	Number of completed referrals (completed individual family referrals documented by a report of the service provided)	Increase over time in the proportion of completed referrals (completed individual family referrals documented by a report of the service provided)

III. GENERAL REQUIREMENTS

1. Complete the grant application online at NJDOH SAGE at www.sage.nj.gov
2. Internet capability and resources, including connection to an IP (internet provider) such as Verizon, Comcast, Clear or other IP.
3. Show evidence of networking and alliance building capabilities required to implement the proposed project initiative with non-profit organizations such as but not limited to CBOs, FBOs, schools, Community Health Center (FQHC), Regional Perinatal Consortia, Pediatric Clinical Providers, Home Visiting Programs, Chronic Disease Prevention Programs, local government, and others. Provide at least one letter of support outlining the relationship or intended relationship with a community partner.
4. Attend all meetings related to this Grant Program; including the mandatory Technical Assistance (TA) meeting for all Applicants interested in applying for this RFA. One or more representatives must attend Technical Assistance meetings (dates to be determined). TA meetings will be facilitated by NJDOH/FHS.

IV. TECHNICAL ASSISTANCE

1. The NJDOH/FHS will provide technical assistance to grantees through conference calls and/or in-person meetings. The conference calls will address specific implementation challenges and provide grantees an opportunity to showcase progress.
2. Site visits will be conducted by NJDOH/FHS, as appropriate.
3. When required, all grantees will participate in meetings or webinars and, maintain open channels of communications with the NJDOH/FHS.

V. FUNDS AVAILABILITY

It is expected that for the first year, a total of approximately $500,000 will be available for funding for the Central Intake Initiative. These funds are available from a combination of federal Maternal and Child Health Block and Race to the Top: Early Learning Challenge grants.

The award of grants under this announcement is contingent upon the continued receipt of these federal funds by the NJDOH/FHS. The Department anticipates funding 3-6 applicants who can successfully meet the program and project criteria described in this announcement. Award amounts are expected to be between $50,000 to $100,000 per county served. Population size, geographic distribution, and existing agency infrastructure will be considered in determining award levels.

This competitive RFA is for a period of three years. Year 2 and 3 Budget Periods will be for one year and are dependent upon the availability of funds. In subsequent years, the agency must submit a noncompetitive health service grant application. Each year continuing funding is contingent upon the availability of funds; timely accurate submission of reports; an approved annual plan; and satisfactory progress toward completion of the current year's contract objectives; and a well-defined sustainability plan post the three-year award period.

Awards will be made based on the quality of the applicant proposal(s) and pending the availability of funds. Funding decisions will be made to ensure the broadest possible coverage, in terms of both geography and prioritized target populations to be served.

Indirect costs are not allowable expenses under this grant.

Funding under a grant is expressly dependent upon the availability of funds to the Department appropriated by the State Legislature from State or Federal revenue or such other funding sources as may be applicable. The Department shall not be held liable for any breach of this agreement, because of the absence of available funding appropriations. The grant award will further be contingent upon the fiscal and programmatic completeness of your application, as well as the fulfillment of the current grant objectives.

The Department will not be able to provide cash payment until a fully executed Notice of Grant Award is in place.

VI. ELIGIBILITY

The awarding of this grant is on a competitive basis and is contingent upon applications deemed fundable according to the RFA review process by NJDOH officials and compliance, **per each year of the grant cycle,** with:

- The NJDOH Terms and Conditions for Administration of Grants
- Conditions stated in this RFA

Eligible applicants include but are not limited to local health departments, not-for-profit agencies and other agencies that provide dedicated maternal and child health services and that meet the requirements of this RFA.

All applications that meet the minimum requirements will undergo a review process, as described below. Any agency or program that has been disbarred or is under suspension by the NJDOH or other governmental agency is not eligible.

All information submitted with your application is subject to verification during pre-decisional site visits and review by NJDOH staff. Verifications may include, but are not limited to, review of client records without identifiers, credentials of staff, progress reports submitted to funders, fiscal policies, procedural policies (including cultural competency policy) and procedures, etc. Submission of unverifiable information in this proposal may result in an agency not receiving any funds.

VII. PROOF OF ELIGIBILITY

Applicants are required to submit financial documents, **per each year of the grant cycle,** in accordance to the NJDOH Cost Controlling Initiatives. **Failure to provide required documentation by the date of application submission will result in the application being deemed non-responsive.** Please attach the requested documents in word or PDF to your application through the NJDOH System for Administering Grants Electronically (SAGE):

1. Valid Internal Revenue Services (IRS) 501(c) (3) tax exempt status.
2. Statement of Total Gross Revenue and/or Annual Report (if applicable). If grant is less than $100,000 and agency doesn't receive any other funds from the state or federal government an audit report is not required. Agency should submit the Statement of Total Gross Revenue in order to determine if an audit report is required.
3. Tax Clearance Certificate is to be submitted—Application for Tax Clearance can be obtained at http://www.state.nj.us/treasury/taxation/busasst.shtml (fee of $75.00 or $200.00).

4. NJ Charities Registration- If your organization is registered with the NJ Charities Registration then each year a "Letter of Compliance" from the Division of Consumer Affairs must be obtained. All registered charities must renew their registration yearly. For more information contact and forms can be found @ hhtp://www.state.nj.us/lps/ca/charity/charfrm.htm

VIII. APPLICATION AND DELIVERABLES

The Department of Health (NJDOH) requires all grant applications to be submitted electronically through our System of Administering Grants Electronically (SAGE) using font: Times New Roman 12- point font, single space and no special characters.

Grant Application Timeline:

- An email "Notice of Intent to Apply" must be sent to the Program Manager no later than 3:00 p.m. on January 15, 2015. Contact information is provided below:
  Anna M. Preiss, Research Scientist
  Central Intake for Maternal, Infant and Early Childhood Services
  Anna.Preiss@doh.state.nj.us
- A Bidder's Conference/ Technical Assistance Meeting will be held for all eligible applicants on January 29, 2015**.** Location details will be provided, via email, by January 26, 2015.
- Applications must be submitted **no later than 3:00 p.m. on March 2, 2015.**

Paper submissions will not be considered**. Incomplete grant applications will not be considered and will be deemed as non-responsive**. Applications that do not meet the above criteria will not be considered and will be rejected**. Selected applicant will be notified of funding decisions on or about March 30, 2015.**

In order to submit a proposal online, via the **System for Administering Grants Electronically (SAGE):**

- ***If your organization is already registered in SAGE****, you will be able to logon and begin the application process once the application is available (date will be provided at the Bidders' Conference/ Technical Assistance Meeting).*

- ***If your organization has never registered in SAGE****, you will be sent guidance for gaining access after your "Notice of Intent to Apply" has been received.*

Other Requirements

Progress and expenditure reports addressing work plan activities to be submitted are located in the NJSAGE system:

- Progress Reports must be submitted within ten (10) business days of the end of the program period quarter.
- Expenditure Reports are due at the end of each quarter.
- Budget revisions can be submitted until forty-five (45) days prior to the end of the program period.
- A narrative of the final summary report on the agency's activities under the grant and Final Expenditure Reports are due thirty (30) days after the end of the budget period.

The Application must be uploaded into SAGE, per each year of the funding cycle, and must include the information below, in the order as presented and identified by Section:

Section 1-Background/Organizational Capacity **(20 points)**

- Provide a brief description and history of the organization;
- Provide an organizational chart that describes the location of this program within the organizational structure; and
- Describe the experience of the applicant organization in providing services in the proposed city.
- Describe the major linkages with community (public and private) organizations (e.g., other health care programs, human service agencies, health professional education programs, integrated service networks, school systems, housing programs, etc.).

Section 2- Needs Assessment **(20 points)**

- Identify the proposed target population and service area.
- Identify existing service location in the city to be served.
- Documentation of clients is required including demographics of population to be served including but not limited to age, race, ethnicity, language, insurance status.
- Describe how the proposed program complements existing services in the community.
- Describe the extent to which current referrals are coordinated and integrated with the activities of other community programs serving the same populations(s).
- Identify formal linkages /partnerships/collaborations with at least 10 faith-based organizations and health care systems in your target city.
- Describe both formal (attach letters of agreement) and informal arrangements.
- Include a time specific project plan that demonstrates that the agency/organization will be operational within 30 days of receipt of grant award.

Section 3-Project Plan for Service **Delivery (50 points)**

- Describe the organization's general approach to meeting community/target population of individuals and families.
- Describe the proposed service model and the services to be provided.

- Describe the proposed staffing and agency readiness of the program. (Include ability to hire, facility space.)
- Describe how the proposed projects are most appropriate and responsive to the identified issues related to this RFA.
- Describe the extent to which project activities are coordinated and integrated with the activities of other federally funded, State and local health services delivery projects and programs serving the same population(s).
- Describe, in cases where the site is already operational, how grant funds will enhance existing services, resources and providers to expand accessibility and availability of health care services to underserved populations.

Section 4-Budget and Justification **(10 points)**

- The budget should be developed based on the estimated funding needs to accomplish the proposed project.
- Health Service Grant Application Schedule A, B, and C must be completed.
- Identify the number of full-time equivalents regardless of funding source that will be providing services for the program.
- The budget should be accompanied by a complete and comprehensive budget justification that provides an explanation for each budget line item.
- The budget should be reasonable and appropriate based on the scope of the services to be provided.
- Identify all state and federally funded initiatives in the project area which your agency is funded. (i.e. other state, federal and private foundation funding)

After applications have been scored and ranked by the review committee, NJDOH/FHS staff will review the budget request. An application must receive a minimum score of 70 points to be eligible for funding. The NJDOH/FHS may negotiate specific line items that it determines to be inappropriate, excessive or contrary to the NJDOH/FHS grant policy.

IX. REVIEW PROCEDURES

1. Applications received by the deadline will be screened for compliance with the mandatory requirements by Maternal and Child Health Services staff.

2. **Applications that are incomplete or do not conform to the grant requirements will be deemed as non-responsive.**

3. Applications that meet the screening requirements will be presented to a review committee.

4. The review committee will assess each application according to the Evaluation Criteria described below.

X. SUBMISSION OF APPLICATIONS

The Department of Health requires all grant applications to be submitted electronically through our System for Administering Grants Electronically (SAGE) at www.sage.nj.gov. Grant applications and attachments must be submitted through the NJDOH System for Administering Grants Electronically (SAGE) **by 3:00 p.m., March 5, 2015.** Paper submissions of the application or any attached documentation will not be accepted through regular mail, fax or e-mail. No extensions will be granted and the SAGE System will **automatically lock** out late applications.

If you are a first- time NJDOH applicant whose organization has never registered in the NJDOH SAGE, you must contact the SAGE System Administrator, Cynthia Satchell-Gore, cynthia.satchell-gore@doh.state.nj.us (609) 633-8009, complete a New Agency form, and submit it to the NJDOH. The Department will review the documents to ensure applicants have satisfied all the requirements. When approved, the organizations' status will be activated in SAGE. The SAGE System Administrator will grant permission (via email) or phone call to the organization's Authorized Official informing then they are authorized to access the application in SAGE.

Instructions for New Agency:

- Complete the form ***Adding Agency Organizations into NJSAGE*** identify your validated Authorized Official, or if none, have the Authorized Official register as a new user. The new user (Authorized Official) will be validated with the organization and assigned to the organization.
- **Sign a hard copy of the form *Adding Agency Organizations into NJSAGE* and submit it via e-mail attachment to the SAGE System Administrator, Cynthia.Satchell-Gore@doh.state.nj.us**

Note: If you have previously applied in SAGE, please do not reapply. Your organization/agency information is maintained by the SAGE.

XI. APPLICATION REVIEW AND AWARD SCHEDULE

January 5, 2015	Release of RFA
January 15, 2015	Letter of Intent Deadline Anna.Preiss@doh.state.nj.us
January 29, 2015	Technical Assistance meeting
February 9, 2015	Application open in SAGE
March 2, 2015	Application due in SAGE (3:00 pm)
March 30, 2015	Application review/determination
April 1, 2015	Notice of Grant Award

	Project Begins

Potential applicants are **required** to send a **letter of intent** through email expressing their interest in submitting an application in response to this RFA. Letters of intent must be sent to: anna.preiss@doh.state.nj.us and received **no later than January 15, 2015.** Letter of intent must include:

1. Agency Legal Name
2. Agency Address, City, County, Zip
3. Agency Telephone Number
4. Agency Federal ID Tax #
5. Charitable Organization Registration
6. Agency Mailing Address for Grant Award Notification (if awarded)
7. Name of person who will be entering the grant application on-line
8. E-mail of person completing grant application
9. Statement of whether the applicant agency is already registered in SAGE

XII. NJDOH CONTACT INFORMATION

Grants Management Officer (Fiscal & SAGE Information), Kelly Kirkpatrick, Kelly.Kirkpatrick@doh.state.nj.us (609) 984-1315

Program Management Officer – (Program Information) – Anna Preiss, Anna.Preiss@doh.state.nj.us (609) 292-0653

Evaluation Criteria

Applications will be reviewed in accordance with the Evaluation Criteria contained in the Request for Applications.

- Background/Organizational Capacity (20 points)
- Needs Assessment (20 points)
- Project Plan for Service Delivery (50 points)
- Budget and Justification (10 points)

After applications have been scored and ranked by the review committee, NJDOH/FHS staff will review the budget request. An application must receive a minimum score of 70 points to be eligible for funding. The NJDOH/FHS may negotiate specific line items that it determines to be inappropriate, excessive or contrary to the NJDOH/FHS grant policy.

References:

[1] Perloff J and Jaffee K. Late entry into prenatal care: the neighborhood context. Social Work 1999;44(2):116-128.

[2] Kropp F et al. Increasing prenatal care and healthy behaviors in pregnant substance users. J Psychoactive Drugs 2010;42(1):73–81.

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Appendices

Appendix A
Statewide Background Data

Appendix B
Improving Pregnancy Outcomes Initiative –flow chart

Appendix C
Perinatal Risk Assessment Form

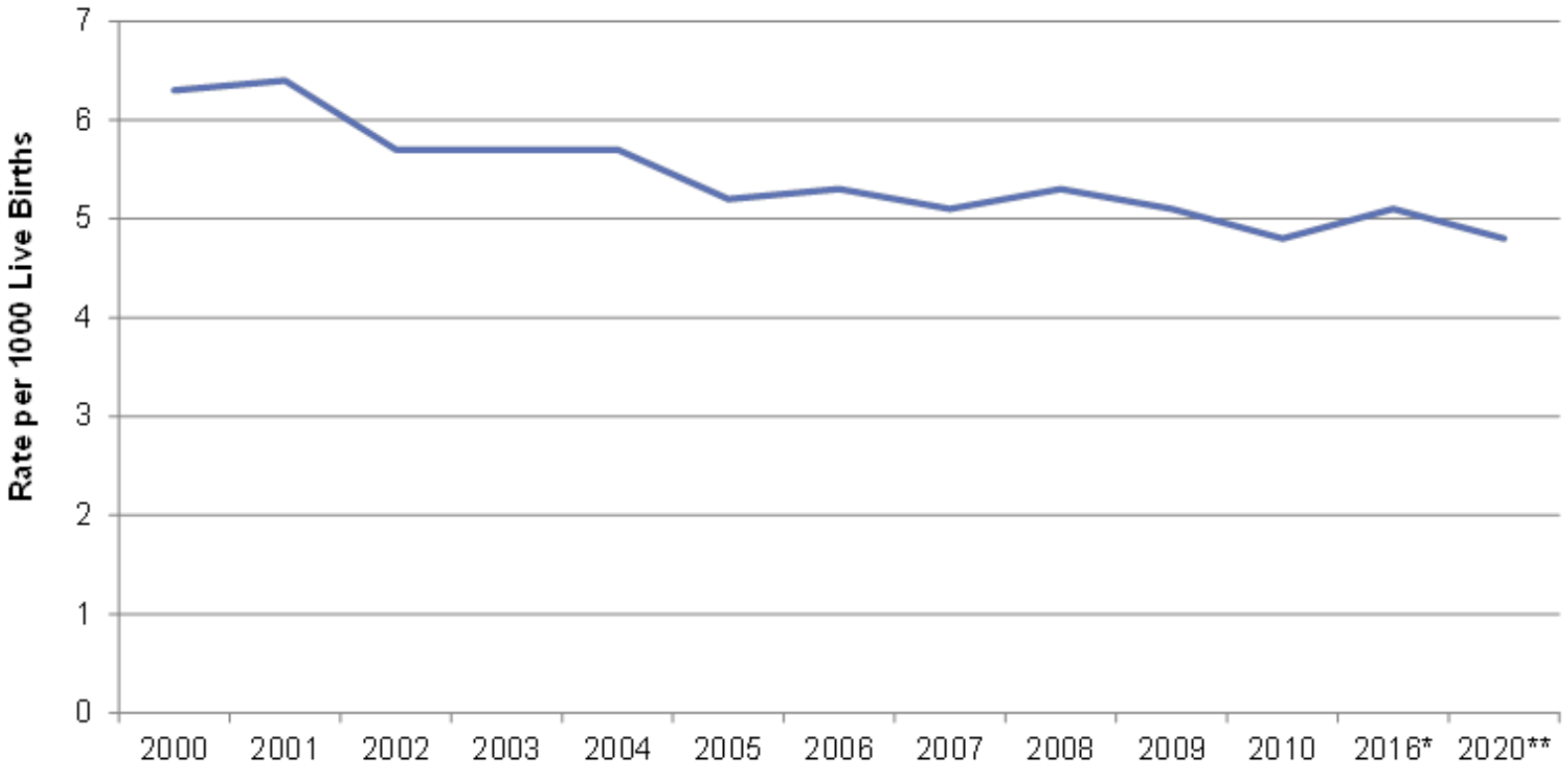
Appendix D
Table of programs and services applicant is to complete to document partnerships

Appendix E
Logic Model

Appendix F
Glossary

Statewide Background Data

Table 1
Infant Mortality Trends



*NJ 2016 State goals **HP2020 goals
Data Source NJSHAD http://www4.state.nj.us/dhss-shad/indicator/index/Introduction.html

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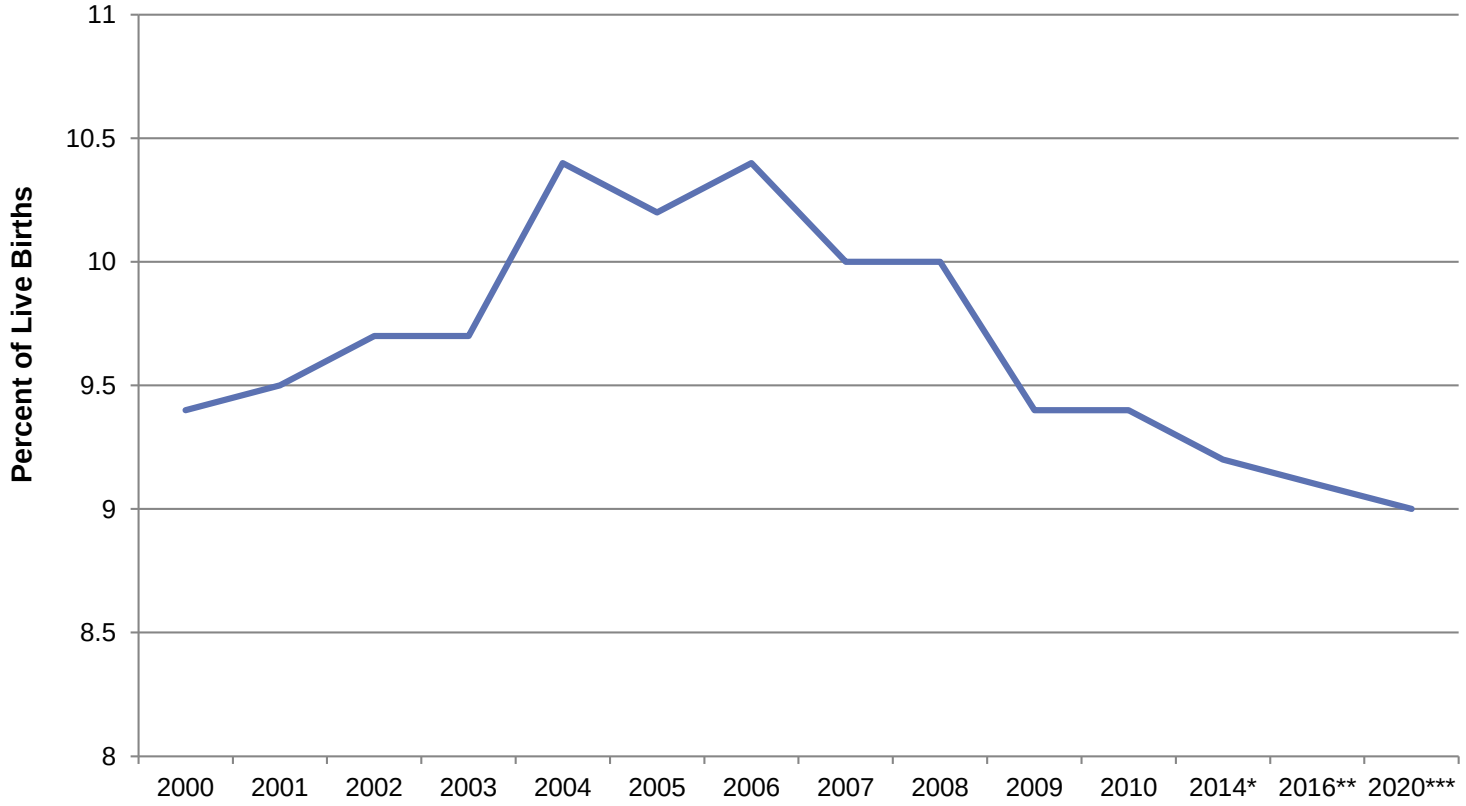
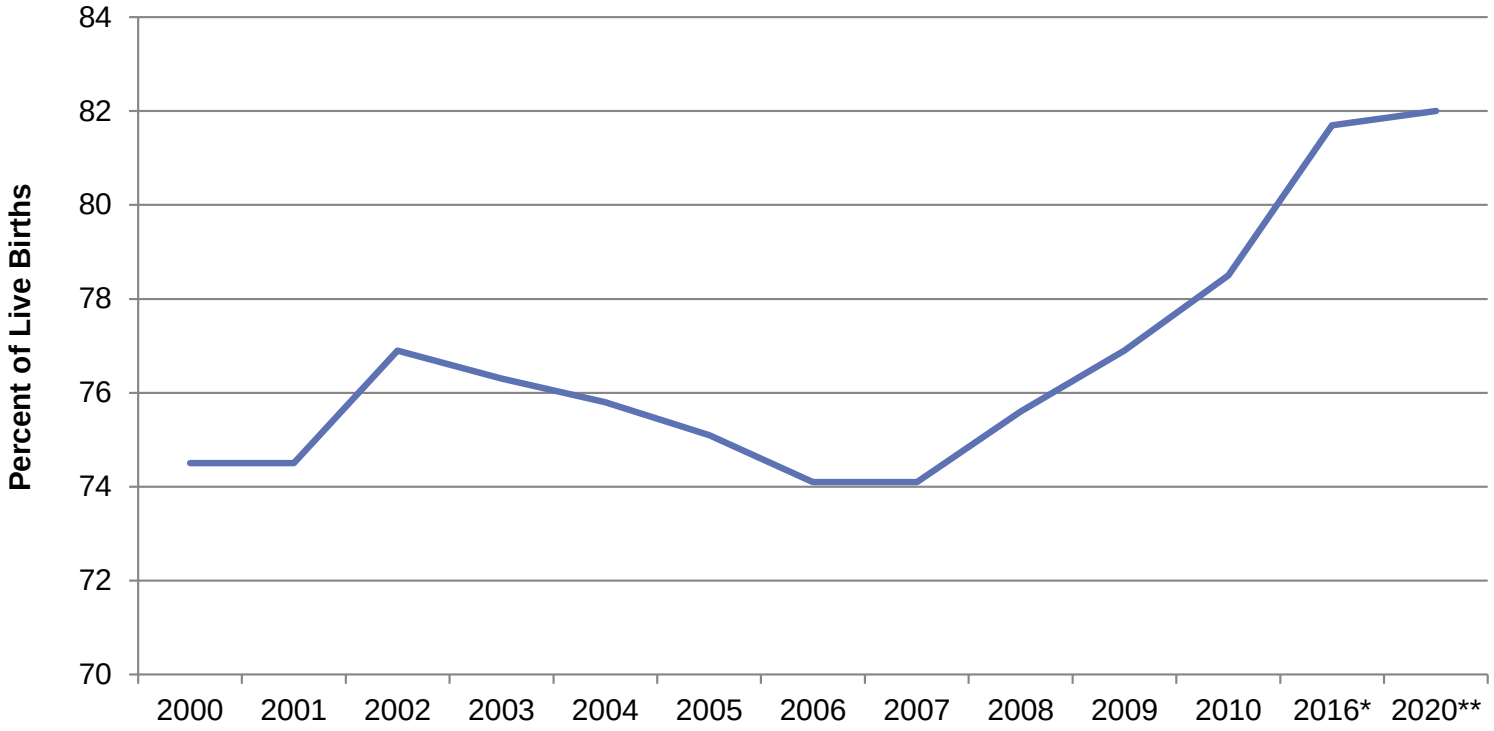
Table 2
Preterm Birth Trends



*ASTHO/MOD Pledge for NJ **NJ2016 State Goal *** HP2020
Goal based on 10% reduction from 2008
Data Source NJSHAD http://www4.state.nj.us/dhss-shad/indicator/index/Introduction.html

Table 3
Trends in First Trimester Prenatal Care



*2016 state goals project an increase to 81.7%
**HP2020 Goal
Data Source NJSHAD http://www4.state.nj.us/dhss-shad/indicator/index/Introduction.html

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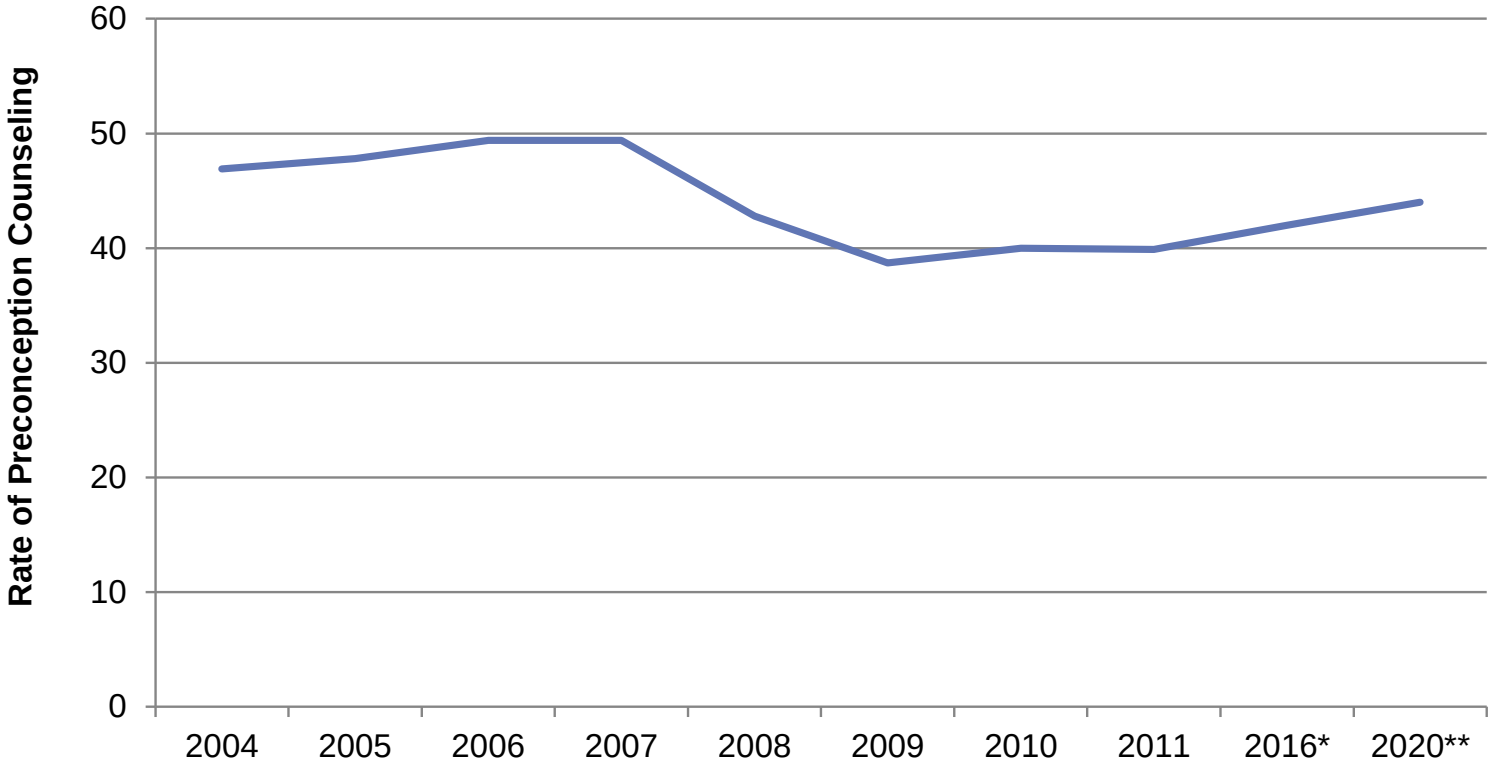
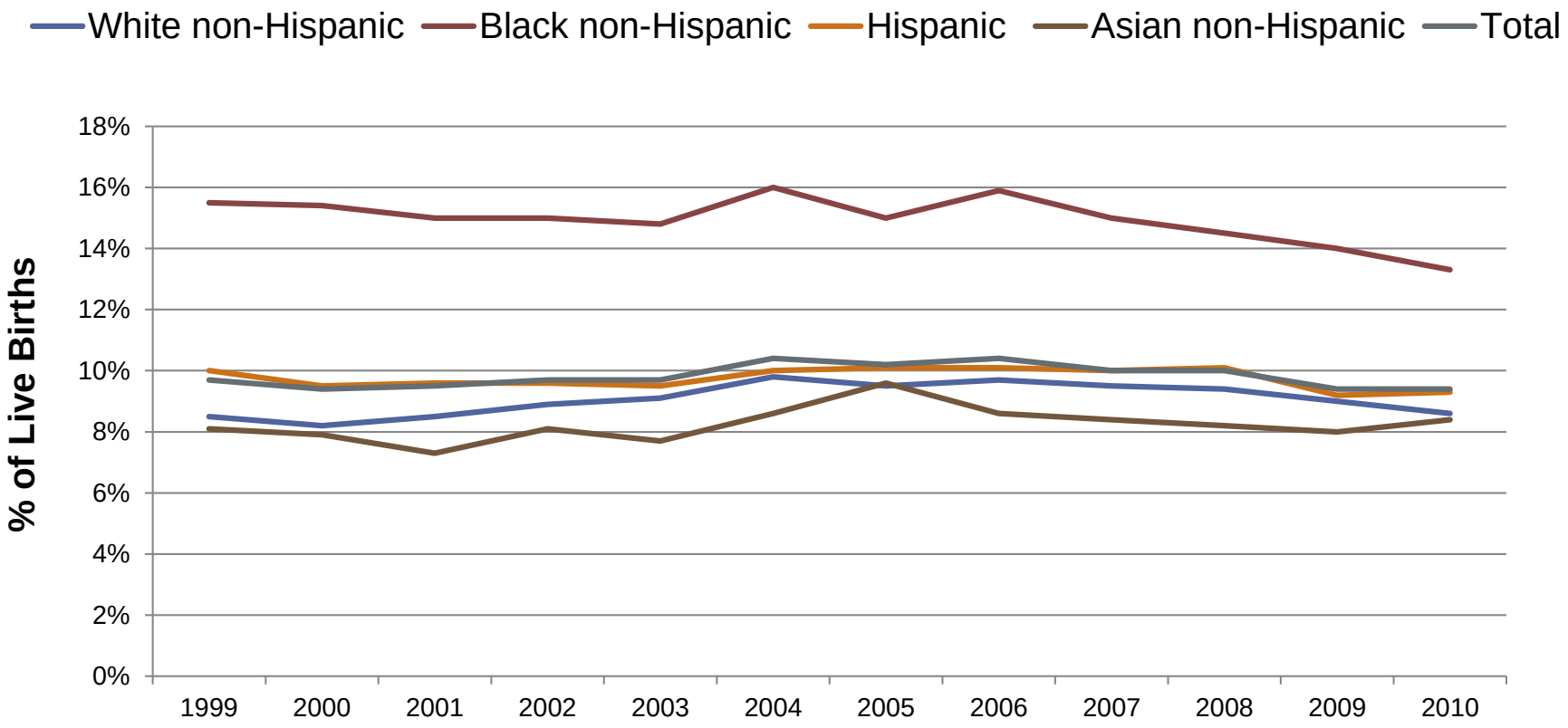
Table 4
Preconception Counseling for Intended Births, PRAMS



*Based on a 5% increase from 2010
**Based on a 10% increase from 2010
Data Source New Jersey PRAMS

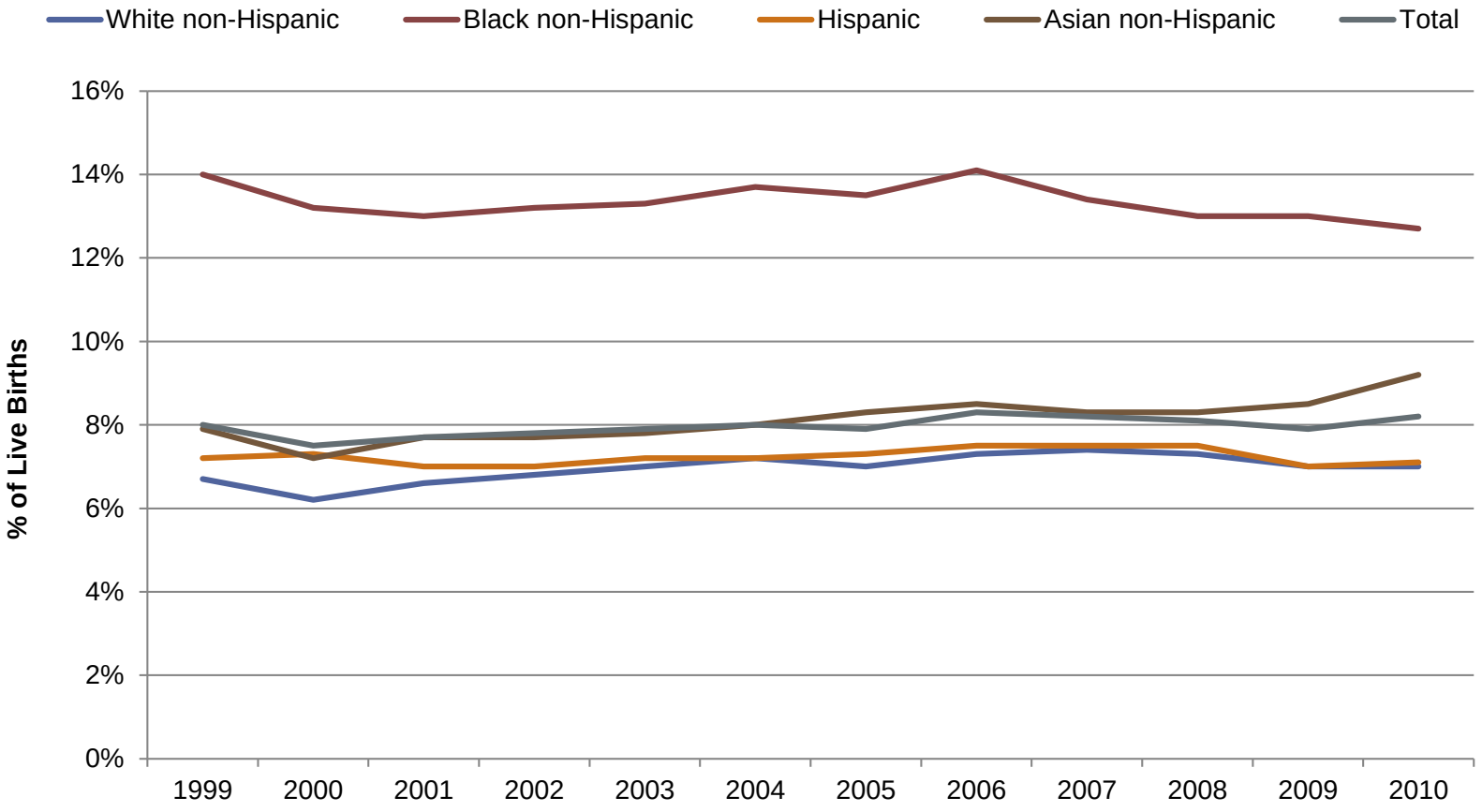
Data by Race and Ethnicity

Table 5
Trends in Preterm Birth



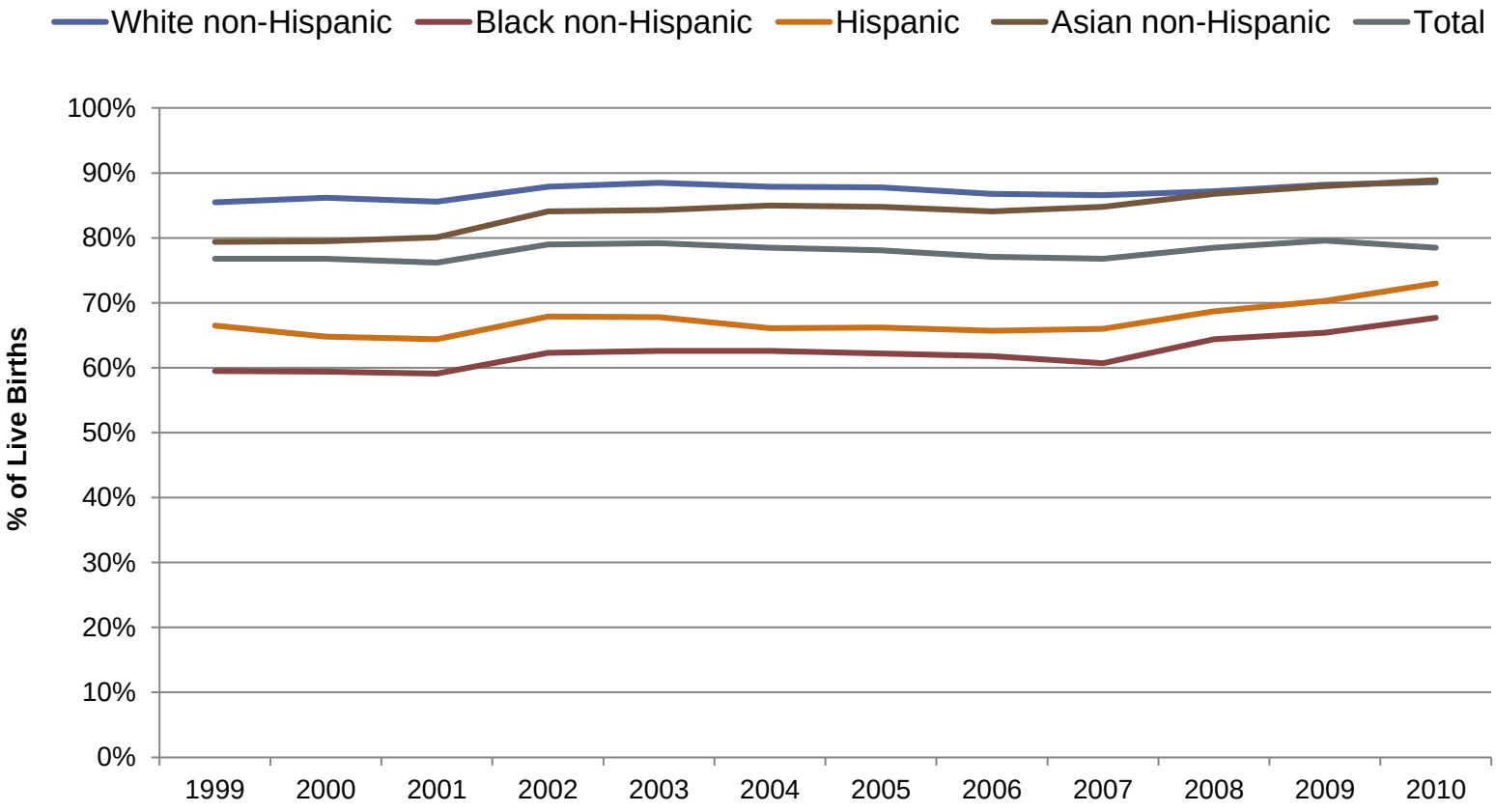
Source: NJDHSS Linked Birth Certificate Infant Death Certificate Files, as of 3/7/2013, New Jersey Residents.
http://www4.state.nj.us/dhss-shad/home
Preterm = less than 37 weeks clinical estimate of the gestation of the infant as judged by the clinician using the best available information, clinical exam and/or ultrasound visualization.
Race/ethnic groups - Hispanic regardless of race; white, Non-Hispanic; black, Non-Hispanic, asian, Non-Hispanic

Table 6
Trends in Low Birthweight Births



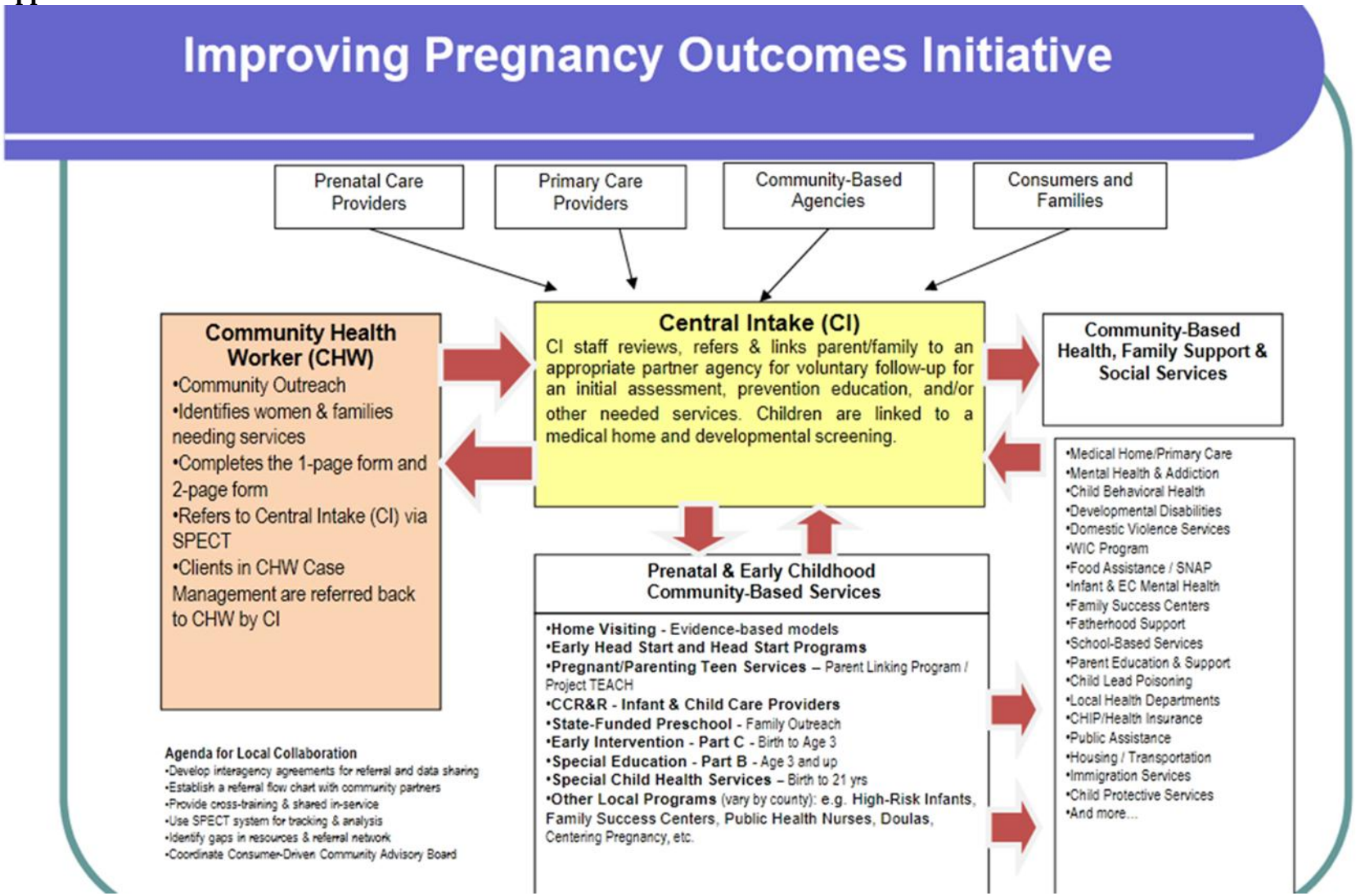
Source: NJDHSS Birth Certificate Files, as of 3/7/2013, New Jersey Residents. http://www4.state.nj.us/dhss-shad/home
Low birthweight = birthweight <2500 grams.
Race/ethnic groups - Hispanic regardless of race; white, non-Hispanic; black, non-Hispanic, asian, non-Hispanic

Table 7
Trends in First Trimester Prenatal Care

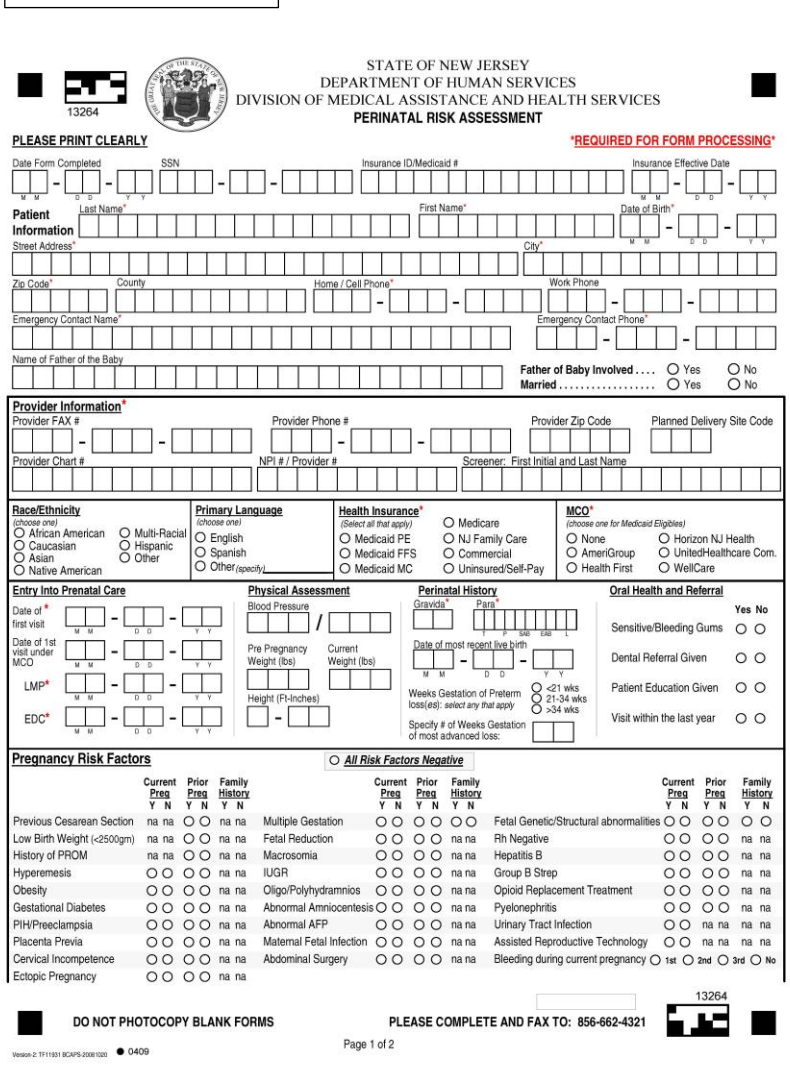


Source: NJDHS Birth Certificate Files, as of 3/7/2013, New Jersey Residents. http://www4.state.nj.us/dhss-shad/home
Initiation of prenatal care self-report as within first 13 weeks on BC.
Race/ethnic groups - Hispanic regardless of race; white, non-Hispanic; black, non-Hispanic, asian, non-Hispanic;

Appendix B


Improving Pregnancy Outcomes Initiative
Prenatal Care Providers
Primary Care Providers
Community-Based Agencies
Consumers and Families
Community Health Worker (CHW)
•Community Outreach
•Identifies women & families needing services
•Completes the 1-page form and 2-page form
•Refers to Central Intake (CI) via SPECT
•Clients in CHW Case Management are referred back to CHW by CI
Central Intake (CI)
CI staff reviews, refers & links parent/family to an appropriate partner agency for voluntary follow-up for an initial assessment, prevention education, and/or other needed services. Children are linked to a medical home and developmental screening.
Community-Based Health, Family Support & Social Services
•Medical Home/Primary Care
•Mental Health & Addiction
•Child Behavioral Health
•Developmental Disabilities
•Domestic Violence Services
•WIC Program
•Food Assistance / SNAP
•Infant & EC Mental Health
•Family Success Centers
•Fatherhood Support
•School-Based Services
•Parent Education & Support
•Child Lead Poisoning
•Local Health Departments
•CHIP/Health Insurance
•Public Assistance
•Housing / Transportation
•Immigration Services
•Child Protective Services
•And more...
Prenatal & Early Childhood Community-Based Services
•Home Visiting - Evidence-based models
•Early Head Start and Head Start Programs
•Pregnant/Parenting Teen Services – Parent Linking Program / Project TEACH
•CCR&R - Infant & Child Care Providers
•State-Funded Preschool - Family Outreach
•Early Intervention - Part C - Birth to Age 3
•Special Education - Part B - Age 3 and up
•Special Child Health Services – Birth to 21 yrs
•Other Local Programs (vary by county): e.g. High-Risk Infants, Family Success Centers, Public Health Nurses, Doulas, Centering Pregnancy, etc.
Agenda for Local Collaboration
•Develop interagency agreements for referral and data sharing
•Establish a referral flow chart with community partners
•Provide cross-training & shared in-service
•Use SPECT system for tracking & analysis
•Identify gaps in resources & referral network
•Coordinate Consumer-Driven Community Advisory Board

Appendix C



STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PERINATAL RISK ASSESSMENT

13264

PLEASE PRINT CLEARLY — *REQUIRED FOR FORM PROCESSING*

Date Form Completed (M M - D D - Y Y) | SSN | Insurance ID/Medicaid # | Insurance Effective Date (M M - D D - Y Y)

Patient Information: Last Name* | First Name* | Date of Birth* (M M - D D - Y Y)

Street Address* | City*

Zip Code* | County | Home / Cell Phone* | Work Phone

Emergency Contact Name* | Emergency Contact Phone*

Name of Father of the Baby | Father of Baby Involved .... ○ Yes ○ No | Married ..... ○ Yes ○ No

Provider Information*

Provider FAX # | Provider Phone # | Provider Zip Code | Planned Delivery Site Code

Provider Chart # | NPI # / Provider # | Screener: First Initial and Last Name

Race/Ethnicity (choose one)
○ African American ○ Multi-Racial ○ Caucasian ○ Hispanic ○ Asian ○ Other ○ Native American

Primary Language (choose one)
○ English ○ Spanish ○ Other (specify)

Health Insurance* (Select all that apply)
○ Medicaid PE ○ Medicare ○ Medicaid FFS ○ NJ Family Care ○ Medicaid MC ○ Commercial ○ Uninsured/Self-Pay

MCO* (choose one for Medicaid Eligibles)
○ None ○ Horizon NJ Health ○ AmeriGroup ○ UnitedHealthcare Com. ○ Health First ○ WellCare

Entry Into Prenatal Care
Date of first visit* (M M - D D - Y Y)
Date of 1st visit under MCO (M M - D D - Y Y)
LMP* (M M - D D - Y Y)
EDC* (M M - D D - Y Y)

Physical Assessment
Blood Pressure /
Pre Pregnancy Weight (lbs) | Current Weight (lbs)
Height (Ft-Inches) -

Perinatal History
Gravida* | Para* (T P SAB ESB L)
Date of most recent live birth (M M - D D - Y Y)
Weeks Gestation of Preterm loss(es): select any that apply ○ <21 wks ○ 21-34 wks ○ >34 wks
Specify # of Weeks Gestation of most advanced loss:

Oral Health and Referral

	Yes	No
Sensitive/Bleeding Gums	○	○
Dental Referral Given	○	○
Patient Education Given	○	○
Visit within the last year	○	○

Pregnancy Risk Factors ○ *All Risk Factors Negative*

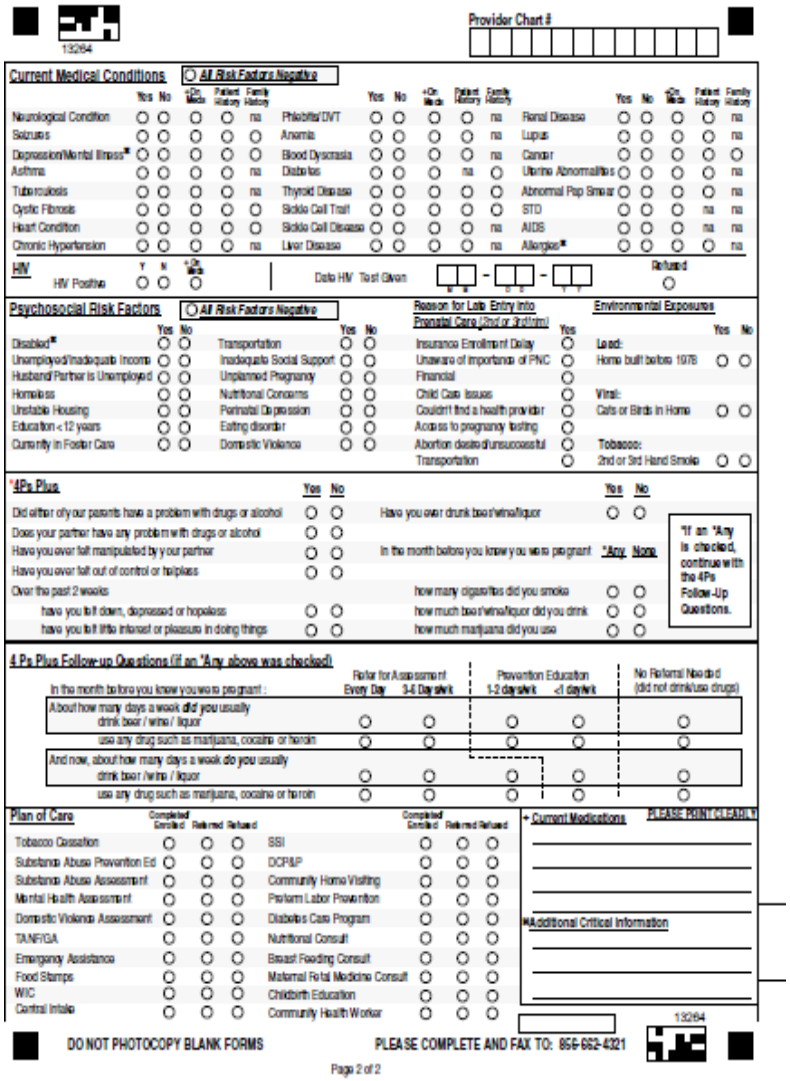
	Current Preg Y	Current Preg N	Prior Preg Y	Prior Preg N	Family History Y	Family History N
Previous Cesarean Section	na	na	○	○	na	na
Low Birth Weight (<2500gm)	na	na	○	○	na	na
History of PROM	na	na	○	○	na	na
Hyperemesis	○	○	○	○	na	na
Obesity	○	○	○	○	na	na
Gestational Diabetes	○	○	○	○	na	na
PIH/Preeclampsia	○	○	○	○	na	na
Placenta Previa	○	○	○	○	na	na
Cervical Incompetence	○	○	○	○	na	na
Ectopic Pregnancy	○	○	○	○	na	na
Multiple Gestation	○	○	○	○	○	○
Fetal Reduction	○	○	○	○	na	na
Macrosomia	○	○	○	○	na	na
IUGR	○	○	○	○	na	na
Oligo/Polyhydramnios	○	○	○	○	na	na
Abnormal Amniocentesis	○	○	○	○	na	na
Abnormal AFP	○	○	○	○	na	na
Maternal Fetal Infection	○	○	○	○	na	na
Abdominal Surgery	○	○	○	○	na	na
Fetal Genetic/Structural abnormalities	○	○	○	○	○	○
Rh Negative	○	○	○	○	na	na
Hepatitis B	○	○	○	○	na	na
Group B Strep	○	○	○	○	na	na
Opioid Replacement Treatment	○	○	○	○	na	na
Pyelonephritis	○	○	○	○	na	na
Urinary Tract Infection	○	○	○	○	na	na
Assisted Reproductive Technology	○	○	na	na	na	na
Bleeding during current pregnancy	○ 1st	○ 2nd	○ 3rd	○ No		

13264

DO NOT PHOTOCOPY BLANK FORMS — PLEASE COMPLETE AND FAX TO: 856-662-4321

Version 2: TF11931 BCAPS-20081020 ● 0409

Page 1 of 2



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Provider Chart #

Current Medical Conditions ○ *All Risk Factors Negative*

	Yes	No	+On Meds	Patient History	Family History
Neurological Condition	○	○	○	○	na
Seizures	○	○	○	○	na
Depression/Mental Illness*	○	○	○	○	○
Asthma	○	○	○	○	na
Tuberculosis	○	○	○	○	na
Cystic Fibrosis	○	○	○	○	○
Heart Condition	○	○	○	○	○
Chronic Hypertension	○	○	○	○	na
Phlebitis/DVT	○	○	○	○	na
Anemia	○	○	○	○	na
Blood Dyscrasia	○	○	○	○	na
Diabetes	○	○	○	na	○
Thyroid Disease	○	○	○	○	na
Sickle Cell Trait	○	○	○	○	○
Sickle Cell Disease	○	○	○	○	na
Liver Disease	○	○	○	○	na
Renal Disease	○	○	○	○	na
Lupus	○	○	○	○	na
Cancer	○	○	○	○	○
Uterine Abnormalities	○	○	○	○	na
Abnormal Pap Smear	○	○	○	○	na
STD	○	○	○	na	na
AIDS	○	○	○	na	na
Allergies*	○	○	○	○	na

HIV — Y | N | +On Meds — HIV Positive ○ ○ ○ | Date HIV Test Given (M M - D D - Y Y) | Refused ○

Psychosocial Risk Factors ○ *All Risk Factors Negative*

	Yes	No
Disabled*	○	○
Unemployed/Inadequate Income	○	○
Husband/Partner is Unemployed	○	○
Homeless	○	○
Unstable Housing	○	○
Education < 12 years	○	○
Currently in Foster Care	○	○
Transportation	○	○
Inadequate Social Support	○	○
Unplanned Pregnancy	○	○
Nutritional Concerns	○	○
Perinatal Depression	○	○
Eating disorder	○	○
Domestic Violence	○	○

Reason for Late Entry into Prenatal Care (2nd or 3rd trim.)

	Yes
Insurance Enrollment Delay	○
Unaware of importance of PNC	○
Financial	○
Child Care Issues	○
Couldn't find a health provider	○
Access to pregnancy testing	○
Abortion desired/unsuccessful	○
Transportation	○

Environmental Exposures

	Yes	No
Lead:		
Home built before 1978	○	○
Viral:		
Cats or Birds in Home	○	○
Tobacco:		
2nd or 3rd Hand Smoke	○	○

4Ps Plus

	Yes	No
Did either of your parents have a problem with drugs or alcohol	○	○
Does your partner have any problem with drugs or alcohol	○	○
Have you ever felt manipulated by your partner	○	○
Have you ever felt out of control or helpless	○	○
Over the past 2 weeks		
have you felt down, depressed or hopeless	○	○
have you felt little interest or pleasure in doing things	○	○
Have you ever drunk beer/wine/liquor	○	○
In the month before you knew you were pregnant	*Any	None
how many cigarettes did you smoke	○	○
how much beer/wine/liquor did you drink	○	○
how much marijuana did you use	○	○

*If an *Any is checked, continue with the 4Ps Follow-Up Questions.

4 Ps Plus Follow-up Questions (If an *Any above was checked)

In the month before you knew you were pregnant :	Refer for Assessment Every Day	Refer for Assessment 3-6 Days/wk	Prevention Education 1-2 days/wk	Prevention Education <1 day/wk	No Referral Needed (did not drink/use drugs)
About how many days a week did you usually drink beer / wine / liquor	○	○	○	○	○
use any drug such as marijuana, cocaine or heroin	○	○	○	○	○
And now, about how many days a week do you usually drink beer /wine / liquor	○	○	○	○	○
use any drug such as marijuana, cocaine or heroin	○	○	○	○	○

Plan of Care

	Completed Enrolled	Referred	Refused
Tobacco Cessation	○	○	○
Substance Abuse Prevention Ed	○	○	○
Substance Abuse Assessment	○	○	○
Mental Health Assessment	○	○	○
Domestic Violence Assessment	○	○	○
TANF/GA	○	○	○
Emergency Assistance	○	○	○
Food Stamps	○	○	○
WIC	○	○	○
Central Intake	○	○	○
SSI	○	○	○
DCP&P	○	○	○
Community Home Visiting	○	○	○
Preterm Labor Prevention	○	○	○
Diabetes Care Program	○	○	○
Nutritional Consult	○	○	○
Breast Feeding Consult	○	○	○
Maternal Fetal Medicine Consult	○	○	○
Childbirth Education	○	○	○
Community Health Worker	○	○	○

+ Current Medications — PLEASE PRINT CLEARLY

#Additional Critical Information

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DO NOT PHOTOCOPY BLANK FORMS — PLEASE COMPLETE AND FAX TO: 856-662-4321

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Appendix D Applicant to complete for local partnerships

Programs and Services:	Provider Name, location	MOU in place
Regional Perinatal Consortia		
Hospitals - specify-OB, pediatrics		
Community Health Center (FQHC) specify OB, peds, adult		
Other Prenatal Clinical Providers		
Pediatric Clinical Providers		
Local Public Health Agency clinics--specify prenatal, peds, adult		
WIC Supplemental Nutrition Program		
MCH Community Outreach Programs		
Healthy Start		
Title X Family Planning		
Lead Poisoning Prevention/ Healthy Homes		
Perinatal Addictions Prevention		
Postpartum Mood disorders		
Chronic Disease Prevention (diabetes, cardiac, cancer, obesity prevention, physical fitness, hypertension)		
Other: e.g. pregnancy testing		
Home Visitation Programs		
Healthy Families-TIP		
Nurse-Family Partnership		
Parents As Teachers		
Other EBHV Programs e.g. Early Head Start		
Local Public Health Nurses		
Other Home Visit Programs:		
County Board of Social Services		
Other Linkages:		
Domestic Violence		
Family Success/Resource Centers		
Fatherhood Services		
Early Intervention Programs		
Infant/Child Care		
Transportation		
Immigration/Refugee Services		
Other Services Linkages:		

Appendix E - Logic Model

New Jersey IPO Logic Model

	Inputs What we invest…	Outputs What we do…	Outcomes Short Term		
Situation **Values** **External Factors**	**Families** **Existing MCH providers** OB/GYN providers Preconception service providers Family Planning providers Primary care Providers) **State-level agencies:** FHS in DHSS (Title V) Department of Children and Families (DCF) Medicaid in DHS **Local-level agencies:** Local Health Departments MCH Consortia Social Service Agencies Hospitals HV Providers Evaluation team Non-governmental early childhood system stakeholders: Child Care Centers Health Care Providers Evaluation team	**Build State Infrastructure** Develop, communicate, & build support for a common vision for Maternal and Child Health (MCH) Identify & commit to shared outcomes & priorities Ensure ongoing, open communication among stakeholders Establish policies that encourage collaboration Support evidence-based MCH models Use data-driven process & assessment to select local grantees Promote standard assessments (PRA) and data systems (EHR) Ensure training & TA is available to local partners/stakeholders Provide guidance & support for local infrastructure building Develop program standards & monitoring systems **Build Local Infrastructure** Translate statewide vision into local priorities Develop shared understanding of roles, responsibilities & outcomes Ensure ongoing, open communication among stakeholders Assess community needs & gaps Build & support a MCH workforce Promote peer-to-peer learning Establish & track measures of fidelity, & use standardized data to drive improvement Develop and enforce systems of accountability Implement standard risk assessment tools & referral system **Deliver Evidence-Based MCH Services** Identify, engage, enroll & retain families Provide MCH services with fidelity & consistency with vision and values Provide referrals & ensure family needs are met Collect data on families served by the MCH program	Shared vision, priorities, & outcomes are reflected in decisions of partner agencies All stakeholders actively participate in planning & implementation activities State & local partners have a shared understanding of systems of standards & monitoring Increase the screening & identification of women in need of MIEC services (G1) Local MCH programs collect and submit complete Performance Standard data MCH workers are well trained & supported in their role Local communities are aware of & support MCH Enrolled families receive MCH services that meet their needs	MCH system reflects the needs & priorities of stakeholders Gaps in available services in high need communities are reduced Families receive well coordinated services that align with their needs Increase referrals to preconception and prenatal services and other MIEC services (G2) Improvement in use of preconception services & early prenatal care Increase utilization of a medical home Increase in use of interconception services Creation of MIEC services Central Intake Advisory Boards	MCH resources are used effectively & efficiently Reduction in preterm births Reduction in low birth weight Reduction of infant mortality Disparities in access to preconception and prenatal care are reduced

Appendix F – Glossary

Sources: http://www.soph.uab.edu/mch-leadership/GLOSSARYVNov02.pdf

Central Intake – is Care Coordination and Systems Integrations that provides one single point of entry for referral access, assessment and support services for women and her family in their community. Central Intake is a county-based client/family screening, assessment, referral, and tracking hub.

Continuous Quality Improvement (CQI) - a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality services or processes which achieve equity and improve the health of the community.

Community Health Worker (CHW) - a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Infant Mortality - The death of a live-born infant before its first birthday

Interconception care - interventions to maximize women's health or pregnancy outcomes that occur between pregnancies.

Life Course Perspective - A life course approach is based on a theoretical model that takes into consideration the full spectrum of factors that impact an individual's health, not just at one stage of life (e.g. adolescence), but through all stages of life (e.g. infancy, childhood, adolescence, childbearing age, elderly age).

Low Birth Weight - Birth weight less than 2,500 grams

Preconception Care - An organized and comprehensive program of health care that identifies and reduces a woman's risk before conception through risk assessment, health promotion, and interventions. Preconception care programs may be designed to include the male partner by providing counseling and educational information in preparation for fatherhood, such as genetic counseling and testing, financial and family planning, etc. May refer to prospective father or mother.

Performance Management Approach - the strategic use of performance standards to guide the development and implementation of specific improvement strategies

Prenatal Care – Prenatal care is a type of preventive healthcare with the goal of providing regular check-ups that allow doctors or midwives to treat and prevent potential health problems throughout the course of the pregnancy while promoting healthy lifestyles that benefit both mother and child.

Preterm Births – Birth before the 37th completed week of gestation.

Social Ecologic Model - identifies and addresses health determinants at multiple ecologic levels to strengthen individual knowledge and skills; enhance social networks and supports; change organizational practices; mobilize communities; and influence policy.